Lived Experiences of Nurses Navigating Barriers in the Rural Health Unit of Siasi, Sulu

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ABSTRACT

This qualitative study explored the lived experiences of nurses working in the Rural Health Unit (RHU) of Siasi, a geographically isolated and disadvantaged area in the province of Sulu, Philippines. Guided by the Constructivist–Interpretivist paradigm, the research sought to uncover the meanings nurses ascribe to their professional roles within a complex socio-cultural and resource-limited context. Eight government-employed nurses assigned to various barangays and island communities participated in in-depth interviews, allowing rich narratives to emerge. Data were analyzed thematically, revealing four overarching themes: *Living the Role Beyond Nursing*, *Navigating Challenges in Resource-Limited Settings*, *Cultural Sensitivity in Care Delivery*, and *Sustaining Commitment Amid Adversity*. The findings highlight the multifaceted responsibilities of rural nurses, who often function beyond their clinical roles to address community health needs, manage scarce resources, and provide culturally attuned care. This study underscores the critical importance of context-specific support systems, continuous professional development, and policy interventions tailored to the realities of rural health work. By illuminating the social constructions of professional identity and resilience among rural nurses, the research contributes to a deeper understanding of nursing practice in underserved communities and offers valuable insights for strengthening primary healthcare delivery in remote areas.

Keywords: rural health nursing, lived experiences, Constructivist–Interpretivist paradigm, geographically isolated and disadvantaged areas (GIDA), Siasi Sulu, qualitative research, thematic analysis, primary healthcare.

INTRODUCTION AND BACKGROUND OF THE STUDY

In the vast and culturally diverse archipelago of the Philippines, rural health units (RHUs) served as the backbone of the country's primary healthcare delivery system. These facilities played a crucial role in delivering essential health services to populations residing in geographically isolated and disadvantaged areas (Department of Health [DOH], 2020). They were often the first and, in many cases, the only point of contact for Filipinos seeking medical care, particularly in remote municipalities where access to hospitals was limited due to distance, transportation challenges, and financial constraints (World Health Organization [WHO], 2021).

At the heart of these RHUs were nurses, who served not only as medical practitioners but also as educators, community advocates, and public health responders. The Philippine Department of Health (DOH, 2020) recognized nurses as integral components of the rural health workforce, emphasizing their role in advancing public health goals. In these rural settings, nurses carried out diverse responsibilities such as administering immunizations, conducting health education campaigns, monitoring maternal and child health, responding to disease outbreaks, and coordinating health programs with local government units. This multifaceted role aligned with the Alma-Ata Declaration's call for primary healthcare providers to engage in preventive, promotive, and curative services (WHO & UNICEF, 1978).

Despite their indispensable contributions, rural nurses frequently performed their duties in environments characterized by inadequate infrastructure, scarce medical supplies, and limited workforce support (Lagrada, 2021). Geographic isolation compounded these challenges, as nurses often traversed difficult terrain or relied on infrequent transportation to reach remote communities (United Nations Development Programme [UNDP], 2020). Furthermore, the sociocultural diversity in rural areas required nurses to navigate differences in language,

traditions, and health beliefs, making cultural competence an essential component of their practice (Labrague et al., 2018).

These realities underscored the resilience, adaptability, and commitment required of rural nurses in fulfilling their professional duties despite systemic limitations. Understanding their lived experiences was therefore essential to identifying context-specific strategies for improving healthcare delivery, ensuring workforce sustainability, and promoting equitable access to quality health services in rural communities.

The lived experiences of nurses in rural settings reveal a dynamic interplay between professional responsibility and personal resilience. Their daily work is shaped by cultural sensitivities, geographic isolation, and the constant need to improvise in the absence of adequate support (UNICEF Philippines, 2023). Many of these nurses carry the emotional and physical weight of caring for entire communities, often with minimal rest or recognition. Nevertheless, their deep sense of commitment and connection to the communities they serve continues to fuel their work, even amidst adversity (DOH, 2023). Exploring these lived experiences is crucial to understanding not only the challenges they face but also the coping strategies and values that sustain them in the demanding landscape of rural health care.

Siasi, a fifth-class municipality in the province of Sulu, exemplifies the complexities of healthcare delivery in rural areas. Located in the Bangsamoro Autonomous Region in Muslim Mindanao (BARMM), Siasi faces persistent challenges related to poverty, transportation, infrastructure, and limited healthcare access. According to the Philippine Statistics Authority (2022), rural municipalities like Siasi exhibit higher rates of poverty incidence, health disparities, and lower access to health facilities compared to urban centers.

As a community health nurse in Siasi RHU we often go beyond the call of duty. In addition to performing clinical tasks, we navigate difficult terrains to reach far-flung barangays, conduct home visits, and provide care amidst sociocultural and linguistic differences. These daily realities shape our distinct professional journey one that is characterized by adaptability, resilience, and a deep sense of service.

Exploring the lived experiences of nurses navigating barriers in this rural setting provides a unique lens through which the current state of public health delivery can be examined. Their stories will reveal not only the barriers they encounter but also the personal and professional strategies they develop to overcome them. These narratives offer valuable insights that can inform local health policies, improve working conditions, and strengthen the overall healthcare system in rural communities.

This study aims to delve into the lived experiences of nurses serving in the Rural Health Unit of Siasi, Sulu, capturing their challenges, coping mechanisms, and reflections as they navigate the complex landscape of rural healthcare.

METHODOLOGY

This study employed a qualitative research design, specifically anchored in Edmund Husserl's Descriptive Phenomenology, to gain a deep understanding of the lived experiences of nurses working in the Rural Health Unit (RHU) of Siasi, Sulu. The qualitative approach allowed the study to explore complex, subjective, and context-dependent human experiences that cannot be fully captured through quantitative methods. Husserl's phenomenological framework guided the process of setting aside personal biases and preconceived notions in order to focus purely on how the participants experience and interpret the barriers they face in their professional roles. Through this lens, the study sought to describe the essence of these experiences as they were lived by the nurses themselves.

In this research study, data was collected through in-depth, semi-structured interviews that provided participants the freedom to express their thoughts and emotions in a natural and open-ended manner. These interviews were designed to facilitate a conversational flow, allowing nurses to reflect on their daily challenges, coping strategies, and the impact of their work environment on their well-being and performance. The flexibility of qualitative interviewing enabled the researcher to probe deeper into emerging themes and follow up on meaningful insights shared by the participants.

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The use of a qualitative design in this study, allows for the exploration of the nuanced and multifaceted nature of rural healthcare delivery, which is often shaped by contextual factors such as limited resources, geographical isolation, sociocultural dynamics, and institutional support systems. By capturing the voices and experiences of frontline healthcare workers, the study aimed to generate insights that are grounded in real-world experiences, thereby contributing to a more comprehensive understanding of the challenges faced by rural nurses and informing possible improvements in healthcare policy, administration, and support mechanisms.

The participants of this study were the licensed nurses who were employed at the Rural Health Unit (RHU) of Siasi and have at least one year of continuous work experience in the said facility. This requirement ensured that the participants have sufficient exposure to the healthcare setting and the challenges commonly encountered in rural practice, allowing them to provide meaningful insights into their lived experiences.

The study used a purposive sampling technique, it involves the deliberate selection of individuals based on specific characteristics relevant to the research. In this case, participants were selected because they possess direct experience with the phenomenon being studied namely, the lived experience navigating barriers faced by nurses in rural health unit Siasi,Sulu. This allowed the researcher to collect rich, detailed, and context-specific data from those who were most knowledgeable and experienced in the area of interest.

The study aimed to include six to ten participants, which was consistent with the standards of phenomenological research. This sample size was sufficient to gain in-depth understanding while remaining manageable for thorough analysis. Sampling continued until data saturation was achieved when no new themes, patterns, or significant information emerge from additional interviews. To maintain the focus of the study, specific exclusion criteria was applied. Nurses with less than one year of continuous experience at the RHU of Siasi were excluded, as they may not yet have encountered the full scope of workplace challenges. Additionally, nurses employed on temporary, relief, or contractual status were not included, since their experiences may differ significantly from those of regular staff. Non-nursing personnel and administrative staff were also excluded, as the study focused specifically on the experiences of nursing professionals. Lastly, nurses who were on leave or not actively reporting for duty during the data collection period were not considered.

In this study, the researcher used **in-depth, semi-structured interviews** as the primary research instrument to explore the lived experiences of nurses working at the Rural Health Unit (RHU) of Siasi. The semi-structured interview format allows for a flexible yet focused approach to data collection, enable to engage participants in a conversation about their professional challenges, coping strategies, and the impacts of their experiences on both their personal and professional lives. The researcher developed an interview guide with open-ended questions that explored key themes such as the lived experiences of nurses working in the RHU of Siasi, Sulu, the barriers that nurses face in delivering healthcare services, how they navigate these challenges, and what support mechanisms did they perceive as necessary to improve their practice and well-being.

The interview guide were pre-tested with a small group of nurses to ensure that the questions are clear, relevant, and effective in prompting the necessary responses. Any feedback from this pilot test were used to refine the guide, ensuring that the final version aligns with the research objectives and enhances the quality of data collection. After the interviews, researcher analyzed the transcriptions for recurring themes and patterns, which helped in understanding the commonalities and variations in the nurses' experiences. The use of semi-structured interviews allowed the researcher gain rich, detailed insights into the challenges faced by nurses in the RHU of Siasi, providing the foundation for a deeper exploration of their lived experiences.

To ensure the validity and reliability of the research instrument, the researcher begun developing a semi-structured interview guide with open-ended questions aimed at exploring the lived experiences of nurses at the Rural Health Unit (RHU) of Siasi, Sulu. The interview guide were pre-tested with a small group of nurses in similar settings to assess the clarity, relevance, and effectiveness of the questions. Feedback from the pre-test were used to refine and revise the guide, ensuring it aligns with the research objectives. Additionally, the guide was reviewed by experts in healthcare and qualitative research to confirm its content validity. Once those steps were completed, the final version of the interview guide were used for data collection. During the interviews, the researcher continuedly monitor for **data saturation**, which occurs when no new themes or information are emerging from the interviews. Saturation signals that enough data has been gathered to adequately address the

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research questions, and data collection was stop at this point. After the interviews were transcribed verbatim, the researcher engaged in member checking by returning the transcriptions to participants. This allowed the participants to review their responses for accuracy and provide feedback or corrections. Participants identified discrepancies and clarified any details, those changes were incorporated into the final transcriptions. This iterative process of validation through pre-testing the interview guide, monitoring for saturation, and member checking ensures the validity and reliability of the data, and helps capture a true representation of the nurses lived experiences in the RHU of Siasi.

The data gathering for this study began with careful preparation and planning to ensure that the research process runs smoothly. First, the researcher finalized the interview guide, which consisted of open-ended questions designed to explore the lived experiences of nurses working at the Rural Health Unit (RHU) of Siasi. The questions focused on lived experiences of nurses working in the RHU of Siasi, Sulu, the barriers that nurses face in delivering healthcare services, how they navigate these challenges, and what support mechanisms do they perceive as necessary to improve their practice and well-being. To ensure the guide is effective, the researcher pre-tested it with a small group of nurses to refine the questions based on their feedback.

The interview guide was ready, the researcher sought approval from the Municipal Health Officer of the Rural Health Unit (RHU) of Siasi, Sulu before conducting the study. Upon receiving approval, researcher began the process of obtaining informed consent from the participants. Each participant was provided with a clear explanation of the study's purpose, procedures, and potential risks, and asked for their written consent to participate and to audio-record the interview.

Next, selected participants using purposive sampling, chosen nurses who had at least one year of continuous experience working at the RHU of Siasi. This selection process ensured that the participants had adequate experience to provide insightful and meaningful responses. The researcher reached out to these nurses through the PHN and invited them to participate in the study and screen potential participants for exclusion criteria, ensuring that only those who meet the inclusion requirements are selected.

Once the participants agreed to take part in the study, the researcher scheduled the interviews at times that are convenient for them and confirm the scheduled interviews a day before the appointment to ensure that the participants are still available. Interviews took place in a quiet and private setting within the RHU to guarantee confidentiality and minimize distractions.

During the interviews, the researcher began briefly self-introduction, explained the study’s goals once again, and remind participants that their participation was voluntary and confidential then proceed to ask the open-ended questions in the interview guide, encouraging participants to share their personal experiences in detail. The semi-structured nature of the interview allowed follow-up questions and explore any interesting insights that arise during the conversation. Researcher audio-recorded each interview (with the participant's consent) to ensure that all responses were accurately captured. Additionally, took notes to document non-verbal cues and any contextual observations that could provide further understanding of the interviews.

After each interview, researcher transcribed the recordings verbatim, ensuring that all responses are accurately captured then cross-check the transcriptions with the original recordings to ensure accuracy and completeness. If any parts of the interview are unclear, researcher contacted the participant for clarification.

The data analysis began after all the interviews have been transcribed. Researcher used thematic analysis to identify recurring themes, patterns, and key insights in the responses. This involved coding the data to group similar ideas and experiences together. Researcher continued to interview the participants until **data saturation** was reached, which means that no new themes or information were emerging from the additional interviews. This ensured that the study has captured a comprehensive and well-rounded understanding of the nurse’s lived experiences.

Throughout the data gathering process, researcher ensured that confidentiality was maintained. All audio recordings, transcriptions, and field notes were stored securely and anonymized to protect the identities of the participants. Ethical considerations adhered to, and participants were reminded that they can withdraw from the

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study at any time without any consequences.

This study strictly adhered to ethical principles to ensure the rights, privacy, and well-being of all participants. Before the interview, informed consent were obtained from all participating nurses. Participant were given a written consent form that clearly explains the purpose of the study, its significance, and the voluntary nature of their participation. Participants will also be informed that they have the right to withdraw from the study at any time without any negative consequences.

To maintain confidentiality and anonymity, all responses were kept strictly private. No personally identifiable information included in the research findings, and all responses were coded to prevent any link between participants and their responses. Access to participants audio- recorded responses were restricted to the researcher only. The study complied with the **Data Privacy Act of 2012 (Republic Act No. 10173),** which mandates the protection of personal information. All responses were securely stored in password-protected electronic files, and after the study was completed, it was retained for a specific period before being permanently deleted to ensure privacy and security. No unauthorized third parties had access to the data at any point.

In the refinement and enhancement of this research manuscript, the researcher made limited use of artificial intelligence (AI), specifically OpenAI's ChatGPT, as a tool to assist in the language polishing, formatting, and synthesis of ideas for clarity and coherence. The AI was not used to generate original data, fabricate findings, or analyze interview transcripts. Its role was strictly limited to grammar correction, improving sentence structure, and organizing thematic discussions in alignment with qualitative research standards. All content, interpretations, and conclusions were based on the actual data collected through in-depth interviews and the researcher's critical analysis. The use of AI was conducted in a responsible and ethical manner, ensuring that the authenticity, integrity, and academic rigor of the study were fully preserved. Furthermore, the researcher retained full control over all research decisions and final outputs.

Additionally, the researcher will seek approval from the Municipal Health Officer of the Rural Health Unit (RHU) of Siasi, Sulu before conducting the study.

RESULTS AND DISCUSSION

This chapter presents the thematic findings of the study using Edmund Husserl's descriptive phenomenological approach**,** highlighting the lived experiences of nurses working in the RHU of Siasi, a geographically isolated and disadvantaged area in the province of Sulu. Data were collected through in-depth interviews with eight government-employed nurses assigned to different barangays and island communities within the municipality. From their narratives, four major themes and several subthemes emerged, capturing the essence of their professional journey.

Theme 1: Living the Role Beyond Nursing (For Research Question 1: What are the lived experiences of nurses working in the RHU of Siasi, Sulu?*)*

All-in-One Health Worker

Participants reported being more than just nurses. In Siasi, where manpower is scarce and logistics are challenging, nurses are expected to function as midwives, vaccinators, encoders, utility workers, barangay health educators, and emergency responders.

"Here in Siasi, being a nurse means being everything. We bring vaccines by boat, assist in childbirth, monitor nutrition, and file endless reports."

This experience reflects the deeply **multifunctional role** of health workers in island municipalities. Similar to the findings of **Capuno et al. (2020)** in the Autonomous Region in Muslim Mindanao (ARMM), the thin spread of health workers across distant barangays often requires nurses to act independently, performing multiple tasks without regular supervision or support.

In a study by **Dulay et al. (2019)**, rural nurses in Southern Philippines reported acting as the "default medical

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authority" in communities lacking physicians, taking on roles in maternal care, data encoding, emergency referrals, and health education. Likewise, **Valle and Abellera (2018)** noted that in island towns of Quezon province, nurses became practice administrators, communicators, and technical staff—balancing service delivery with documentation and outreach.

Cabrera and Macalindong (2020) found that this multitasking burden leads to role strain, burnout, and feelings of being undervalued, especially when such roles are not officially recognized or compensated. In Siasi, this role expansion is further amplified by difficult sea travel, security concerns, and poor infrastructure, making every task a logistical challenge.

Internationally, similar patterns are seen in studies such as **Lehmann and Sanders (2007)**, which documented how community health workers in under-resourced regions of Africa take on overlapping roles due to workforce shortages. In the Philippines, however, these overlapping functions often fall on licensed nurses, creating a heavier legal and ethical burden.

Overall, the findings highlight that nurses in Siasi are not only clinicians—they are the backbone of local health systems, filling every gap in service delivery. Their all-in-one role, while a testament to their adaptability and dedication, also underscores the urgent need for structured support, fair workload distribution, and job recognition at the local and national levels.

A Calling, Not Just a Career

Despite limited compensation and difficult working conditions, most nurses expressed a sense of duty and fulfillment rooted in community ties and cultural affinity.

"Even when the salary is delayed, I stay because I know the people. They are my neighbors, my relatives. I care for them"

In Siasi, where kinship and community loyalty are strong, service is deeply personal. This reflects Husserl's idea of intentionality—nurses attribute meaning to their daily tasks not through external reward, but through intrinsic purpose.

This finding resonates with the study of **Uy and Soriano (2020)**, who found that nurses in rural Mindanao often remain in their posts not because of financial incentives, but due to strong emotional bonds with their communities and a deeply ingrained sense of responsibility. Similarly, **Lucero et al. (2018)** emphasized that nurses assigned in geographically isolated and disadvantaged areas (GIDA) often frame their work as a moral and spiritual duty, especially when serving culturally familiar populations.

In a related study, **Montayre and Montayre (2021)**, examining rural nursing in the Visayas, noted that nurses described their work as "mission-driven," often sacrificing personal comfort and safety in favor of community health. This intrinsic motivation often sustains them in the absence of external support systems. Moreover, **Barroga and Canoy (2019)** found that Filipino nurses working in conflict-affected areas of ARMM exhibited high levels of altruism and empathy, which helped them maintain their commitment even under extreme resource constraints.

These studies affirm that for nurses in places like Siasi, the profession is not just a career path—it is a vocation rooted in shared culture, social obligation, and a profound desire to uplift their communities despite the hardships they face. Their unwavering commitment highlights the resilience and heart of rural healthcare in underserved areas of the Philippines.

Theme 2: Barriers Embedded in Geography and Governance (*For Research Question 2: What barriers do they encounter in delivering healthcare services?*)

Distance, Weather, and Transport Limitations

Many nurses are assigned to barangays on smaller islands, reachable only by motorboat. During bad weather, travel becomes dangerous or impossible, delaying immunizations, check-ups, and medical deliveries.

"Sometimes, we have to cancel barangay visits because of strong currents or no boat driver. Our patients wait for weeks."

This challenge is unique to island RHUs like Siasi, where transportation logistics are not just about distance, but also depend heavily on the availability of boats, fuel, and experienced boatmen willing to navigate rough waters. While mainland rural health units also face logistical constraints, Siasi's fragmented geography severely limits the continuity and timeliness of healthcare delivery.

Delos Reyes (2021), in a study conducted across the Sulu archipelago, emphasized that sea conditions and high transportation costs are among the top barriers to implementing outreach services. Nurses often report feeling helpless when weather-related cancellations cause scheduled vaccination drives or maternal care visits to be postponed indefinitely. Similarly, Amparo and Enriquez (2018) observed that in Tawi-Tawi, rural health teams frequently miss target coverage for Expanded Program on Immunization (EPI) campaigns due to poor access to outer island barangays during the rainy season.

In the national context, Department of Health (DOH, 2020) monitoring reports confirm that island-based RHUs have consistently lower service coverage rates compared to their mainland counterparts, particularly for maternal and child health indicators. Salcedo and Mariano (2019) also argue that in GIDA areas, geographic barriers intensify health inequities, particularly for indigenous and Muslim populations, by preventing timely diagnosis and treatment.

In Siasi, the lack of institutional transport—such as government-assigned boats or fuel allocations—means that nurses sometimes rely on private operators or their own funds, making outreach both unsafe and unsustainable. These travel challenges also contribute to staff fatigue and occupational risk, especially when nurses must cross open waters with medical equipment, vaccines requiring cold storage, and little to no communication signal.

The nurses lived experiences affirm that geography is not a passive backdrop, but an active barrier to equitable healthcare delivery. Without dedicated maritime logistics support and weather-adaptive planning, island municipalities like Siasi will continue to struggle with consistent service delivery—placing both frontline workers and patients at risk.

Supply Shortages and Delayed Procurement

Participants described frequent shortages of essential drugs, medical equipment, and logistical support. There are delays in the procurement of medicine and vaccine supplies from the provincial DOH.

"Our cold chain for vaccines failed once because the solar freezer broke and we had no fuel for the generator."

This account illustrates the fragile infrastructure underpinning vaccine storage and distribution in island health units. Maintaining the cold chain is critical for vaccine efficacy, yet constant power interruptions and lack of resources make it difficult to uphold.

The challenges faced in Siasi align with findings by Morales (2019), who studied isolated municipalities in Sulu and found that these areas often depend on infrequent, irregular deliveries of medical supplies. These delays are further exacerbated by armed conflict, unpredictable sea conditions, and poor coordination between municipal and provincial health offices. This results in stock-outs, forcing nurses to ration medicines or reschedule patient treatments.

Similarly, Lazo and Cruz (2020) highlighted that in rural ARMM, breakdowns in the supply chain are common due to limited transport options, insufficient cold chain equipment, and inadequate funding for fuel and maintenance. These systemic issues contribute to gaps in immunization coverage and delayed treatment for common illnesses.

In a related study, Santos et al. (2018) reported that in geographically isolated regions of Mindanao, health workers often face the dual burden of managing scarce supplies while trying to document and report stock levels

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accurately tasks that increase workload and stress. Furthermore, Abdullah and Espinosa (2021) underscored the negative impact of supply shortages on community trust, noting that patients may lose confidence in the health system when promised treatments or vaccines are unavailable.

The nurses' narratives in Siasi reflect a broader systemic problem of inadequate logistics management in remote island municipalities, where infrastructure, funding, and communication breakdowns combine to undermine healthcare delivery. Addressing these supply chain vulnerabilities is crucial for improving health outcomes and supporting frontline workers in challenging environments.

Theme 3: Cultural Adaptation and Emotional Endurance (*For Research Question 3: How do these nurses cope with or navigate the challenges they face?*)

Navigating Local Beliefs and Traditions

Some patients refuse hospital referrals or prescribed treatments due to traditional or religious beliefs. Nurses must use tact, cultural understanding, and negotiation to encourage health-seeking behavior.

"We respect their beliefs, especially the elders. Sometimes, we explain using local stories so they will listen."

This experience reflects the intricate cultural-religious fabric of Siasi, where Tausug customs and Islamic practices significantly influence how community members perceive illness, healing, and modern medicine. Nurses often find themselves bridging two worlds balancing the biomedical model with indigenous belief systems.

Teehankee (2022) described nurses in many parts of Sulu as "cultural translators," who navigate the delicate interplay between Western medical protocols and local traditions. Their role extends beyond clinical care to include education that is contextually and spiritually appropriate.

Supporting this, **Sali et al. (2023)** examined healthcare delivery in ARMM and highlighted that health workers who integrate local narratives and religious values into their health education efforts tend to achieve better community acceptance and cooperation. Similarly, **Datumanong and Santos (2021)** reported that in Muslim-majority municipalities, leveraging traditional communication methods—such as storytelling and involving community and religious leaders—enhances trust and adherence to treatment regimens.

Furthermore, **Boholano et al. (2020)** noted that health programs that fail to acknowledge indigenous healing practices and community hierarchies often face resistance, resulting in poor health outcomes. Nurses who understand and respect these dynamics can more effectively facilitate referrals, vaccinations, and maternal care services.

Internationally, studies such as **Kassam et al. (2021)** in Indigenous communities in Canada emphasize that health providers acting as mediators between biomedical and traditional health beliefs improve patient engagement and health equity—paralleling the experiences reported by nurses in Siasi.

In sum, the nurses' lived experience underscores the importance of culturally competent care, where success depends not only on clinical expertise but also on humility, respect, and creative communication tailored to the community's cultural and spiritual worldview.

Theme 4: Hopes for Support and Change (*For Research Question 4: What support mechanisms do they perceive as necessary to improve their practice and well-being?*)

Facility Improvement and Reliable Logistics

Participants emphasized the urgent need for permanent, improved health facilities in island barangays. Many barangay health stations are outdated or poorly constructed, often lacking essential infrastructure to support basic healthcare functions.

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"Some of our barangay health stations are too old and need facility improvement."

Reliable power sources are especially critical for maintaining cold chains necessary for vaccine storage. The nurses also highlighted the need for faster and more consistent access to emergency supplies, which are often delayed due to logistical challenges.

The current state of facilities compromises the quality of healthcare delivery and affects the morale and safety of health workers. Without durable buildings, steady electricity, and timely supply chains, nurses struggle to perform their duties effectively.

These concerns echo findings from the **2023 BARMM Health Sector Assessment**, which reported that many barangay health stations in Sulu operate with inadequate infrastructure—including lack of electricity, water, and sanitation facilities conditions that deter both health workers and community members from fully utilizing these services.

Improving facility conditions and logistics is not only about physical structures but also about enabling functional healthcare environments that support both providers and patients in remote island settings like Siasi.

This is a **basic structural need** echoed in the 2023 **BARMM Health Sector Assessment**, which reported that many barangay health posts in Sulu operate without power, water, or sanitary toilets—factors that discourage both workers and patients.

Fair Compensation and Continuous Training

Nurses requested timely salaries, hazard pay (especially when crossing seas), and access to updated clinical training without needing to travel to far provinces.

"Our job is high-risk. We hope the LGU and DOH recognize that we deserve compensation and growth."

They emphasized that irregular salary releases, absence of sea travel allowances, and limited access to capacity-building seminars are demotivating. Most training opportunities are conducted in Zamboanga or Jolo, making it difficult for Siasi-based nurses to attend due to cost, travel risks, and understaffing.

This appeal is supported by **Cabalquinto and Panganiban (2018)**, who called for **mobility and risk allowances** for nurses assigned to remote islands in Basilan and Sulu. They argued that healthcare workers in these areas face environmental and operational hazards that warrant special financial and institutional support.

More recently, the **World Health Organization (2021)** emphasized that retention of health workers in GIDA (Geographically Isolated and Disadvantaged Areas) hinges on two core pillars: **fair compensation** and **continuous professional development (CPD)**. The lack of either can contribute to burnout, resignations, or migration to urban areas or abroad.

Further, **Abubakar and Lim (2023)** highlighted how decentralized health systems in BARMM need to invest more in localized training to address both skill gaps and morale issues among frontline health workers. Their study recommended deploying mobile training units or virtual modules accessible even in areas with unstable internet connections solutions well-suited to Siasi's context.

The **BARMM Human Resources for Health Strategic Plan 2022–2026** also identifies equitable salary structures and routine training as non-negotiable elements in strengthening the health workforce in island municipalities.

In sum, fair pay and access to growth opportunities are not simply incentives they are forms of recognition that affirm the sacrifices and professional dignity of nurses serving on the frontlines in Siasi. Without them, workforce stability and service quality will remain fragile.

The lived experiences of nurses in Siasi's RHU reflect a unique convergence of **geographical isolation, cultural**

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complexity, and institutional neglect, yet are marked by resilience, creativity, and deep community commitment. Their stories reveal a reality where nurses function not only as caregivers, but also as educators, navigators, peacebuilders, and bridge-builders in a fragile health system.

Using **Husserl's phenomenological lens**, we see their work as an intentional, meaning-making endeavor a way of affirming their identity not just as professionals, but as community lifelines. Their experiences demand urgent policy attention that goes beyond generic rural healthcare reforms and focuses on the **distinct needs of island municipalities like Siasi**.

Based on the result of the study, what research output can be developed?

Based on the findings of this study, a highly relevant research output that can be developed is a **Localized Nurse Support Framework for Island Communities** (Please see page 46, Figure 2 Conceptual Paradigm), tailored specifically to the realities of geographically isolated and disadvantaged areas (GIDA) like Siasi. This framework may include guidelines for improving rural health infrastructure, a protocol for timely salary and hazard pay disbursement, and a peer-support and wellness program grounded in cultural and spiritual practices. Additionally, a **training module or toolkit for culturally competent care** (Please see appendix C) in Muslim-majority and Tausug communities could be created to enhance nurses' communication and negotiation skills when navigating traditional beliefs. The study also supports the development of a **policy brief or advocacy document** addressed to the Department of Health (DOH) and local government units (LGUs), highlighting urgent needs such as reliable cold chains, continuous clinical training, and constructions of barangay health facilities (Please see Appendix D). These outputs would not only bridge systemic gaps but also empower nurses to deliver more resilient, respectful, and responsive care in resource-constrained island settings.

Conceptual Paradigm

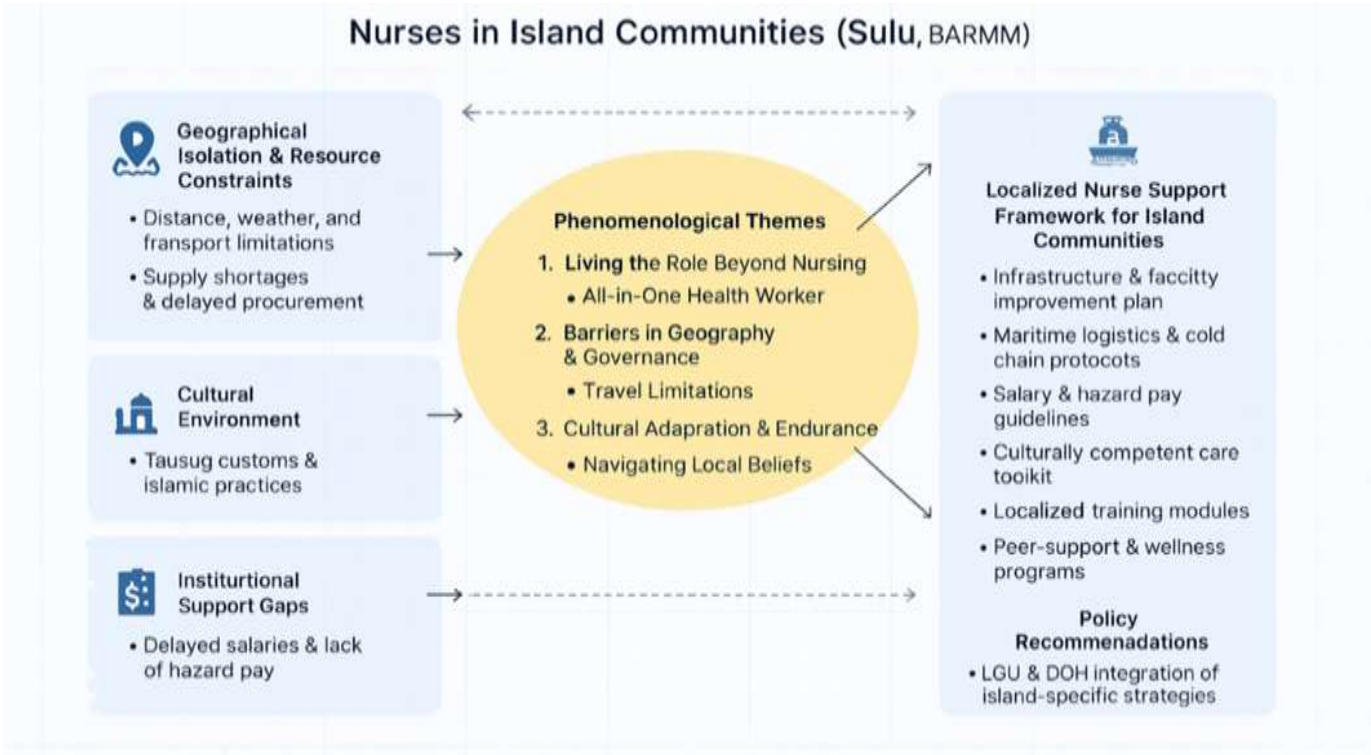

Figure 2: Self-developed Paradigm entitled "Outrigger Model: Steering Lived Experience Toward System Support"

Outrigger Model: Steering Lived Experience Toward System Support

This paradigm treats the Siasi RHU as an outrigger canoe moving across island waters. The **main hull** is the lived experience of nurses—the phenomenological core—while the **outriggers** on the sides are the contextual

forces that can capsize or stabilize practice. The model shows how these forces feed into nurses' day-to-day realities and, with deliberate steering, propel the boat toward structured **system support** and policy action.

On the **left,** the three boxes function as the outrigger floats that keep the vessel upright in rough seas. *Geographical isolation and resource constraints* are the heavy swell—distance, weather, transport limits, and chronic supply delays. *Cultural environment* represents the local currents—Tausug customs, Islamic practices, and kinship ties that shape care, trust, and consent. *Institutional support gaps* are the crosswinds—delayed salaries, limited training, and thin supervisory backing. In the diagram, arrows from these boxes into the center show how these stabilizers (and stressors) directly press on nurses' everyday work.

The **central oval** is the hull carrying the team and cargo—**Phenomenological Themes** distilled from interviews. Nurses "live the role beyond nursing," often acting as vaccinators, birth attendants, educators, encoders, and emergency responders—an *all-in-one* crew. They confront *barriers in geography and governance*, notably travel limits and supply-chain fragility. They practice *cultural adaptation and endurance*, navigating local beliefs to maintain trust and continuity. This core is where experience is converted into momentum; what happens here determines whether the boat drifts or advances.

On the **right**, the action packages are the sail, mast, and rigging that catch the wind and translate experience into motion—**Localized Nurse Support Framework for Island Communities**. Infrastructure and facility upgrades and **maritime logistics/cold chain protocols** are the sturdy mast; **salary and hazard-pay guidelines** are the ballast that keeps the boat steady; **culturally competent care toolkits** and **localized training modules** are the adjustable sail that fits local winds; **peer-support and wellness** is the crew's stamina on long crossings. Beneath this, **Policy Recommendations** (LGU–DOH–BARMM integration) act as the compass and nautical chart—setting direction, standardizing routes, and ensuring resources follow the path nurses actually travel.

The **dashed alignment arrow** across the top is the trade wind of systems coordination—procurement, transport, HR, and financing blowing in the same direction so the sail can work efficiently. The **curved, dashed feedback loop** from policy back to the left-hand boxes is the tide cycle: as policies land (e.g., hazard pay, ferry cold-chain schedules), they alter the very conditions that once destabilized practice, leading to fewer stock-outs, safer travel windows, better morale, and stronger cultural partnership. Monitoring this loop is how the skipper knows when to trim the sail or rebalance the outrigger.

Used operationally, the Outrigger Model is a **design and decision tool:** begin with rapid assessments of the left-side determinants, surface and theme the lived experiences in the center, then select and sequence the right-side interventions that best "catch the wind" for that barangay or island cluster. Progress indicators map neatly onto the parts of the boat—mast (infrastructure uptime, cold-chain integrity), ballast (on-time salary/hazard pay), sail set (completed localized trainings, toolkit use), and crew wellness (burnout, retention, peer-support uptake). Quarterly, revisit the feedback loop to see whether policy has shifted sea conditions and to retune logistics or training.

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